

AMERICAN MEDICAL TIMES

Being a Weekly Series of the New York Journal of Medicine.

No. XXIV.
VOL. IV.

NEW SERIES.

NEW YORK: SATURDAY, JUNE 14, 1862.

{ *Mail Subscribers, \$3 per Ann.*
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ORIGINAL LECTURE.
 Lectures on New Remedies and their Therapeutical Applications. Delivered at the N. Y. Med. Coll. and Charity Hosp. By Sam. R. Percy, M.D., etc. Lecture VII. Resina Jalapæ. —Jalapæ of Commerce. 327

ORIGINAL COMMUNICATIONS.

Report of the Mill Creek Hospital, Fortress Monroe. By Fred' D. Lente, M.D. 328
 Removal of a Tumor Involving the Parotid and Submaxillary Glands; Destruction of Temporo-Maxillary Articulation; Reproduction of Jnt, and Cure

of Patient. By E. S. Cooper, A.M., M.D. 330
 Experiences in the Practice of Military Surgery. By David P. Smith, M.D. 331

REPORTS OF HOSPITALS.

BELLEVUE HOSPITAL:
 Report of Cases of Meningitis Treated with Iodide of Potash. 333

REPORTS OF SOCIETIES.

NEW YORK PATHOLOGICAL SOCIETY:
 Stated Meeting, April 23, 1862. Dr. T. C. Finnel, President, in the Chair. Ovarian Tumors. 334

EDITORIAL ARTICLES.

A Remedy for an Evil. 335
 A Loop of Red-tape Severed. 336

THE WEEK:

Disposition of Sick and Wounded of our Army. 337
 Bellevue Hosp. to Receive Sick and Wounded Soldiers. 337
 The Feeding of our Army. 337
 The Philadelphia College of Physicians and Surgeons. 337

REVIEWS.

Commentaries on the Surgery of the War in Portugal, Spain, France, and the Netherlands, etc. By G. J. Guthrie, F.R.S. Notes on the Surgery of the War in the Crimea, etc. By G. H. B. Macleod, M.D., F.R.C.S.

A Treatise on Gunshot Wounds. By T. Longmore, Esq. 337
 Anatomy, Descriptive and Surgical. By Henry Gray, F.R.S. 337

CORRESPONDENCE.

Connecticut Medical Society 338
 Shelter Cloak-Tent 338

Military Hospitals 338

Foreign Correspondence. By Prof. Charles A. Lee. 339

List of Names of Surgeons and Assist. Surgeons appointed to the Volunteer Regts. of N. Y. State, and the Changes which have occurred, since Mar. 8, '62 340

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

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Circular to Physicians and others.

LOUISVILLE, KY., Jan. 1, 1862.
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WM. T. CUTTER, JR.
NEW YORK, May 1, 1861.

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AUSTIN FLINT, M.D., E. N. CHAPMAN, M.D., Brooklyn.
C. L. MITCHELL, M.D., JAMES E. WOOD, M.D.
W. C. P. BAYLIS, Pharmacutist, Brooklyn, N. Y.

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BY SAMUEL R. PERCY, M.D.,

PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS.

LECTURE VII.

RESINA JALAPÆ.—JALAPIN OF COMMERCE.

GENTLEMEN:—In one of our previous lectures we fully discussed the botanical characteristics and history of the jalap root, so that we need not in the present lecture again refer to them.

There are very few of the new medicinal preparations that vary more in their effects upon the system than the jalapin of commerce. This variation in the strength is owing to the different methods by which the commercial jalapin is prepared. I have seen samples that were but slightly purgative in doses of ten grains, whereas that which is properly prepared should act freely in the dose of one to three grains. The difference in effect is not owing to the variation in the different samples of jalap root used, but to the different methods of preparation by the vendors of the article; for some are not content with giving all the resin the jalap contains, but in addition put with it the watery extract.

A great many analyses of jalap root have been made; all, of course, varying, because different samples of the root have been used. The most complete analysis is that made by Gerber, but there are a large number of others that are equally valuable in a commercial view as the amount of the active principle is given. Of these latter analyses, we shall select several, as they show at a glance the value of the jalap root, both medicinally and commercially.

GERBER'S ANALYSIS.

Hard resin,	78
Soft resin,	32
Slightly acid extractive,	17.9
Gummy extractive,	14.4
Coloring matter,	8.2
Uncryst. sugar,	1.9
Gum with some salts,	15.6
Vegetable albumen,	3.9
Bassorin starch,	0.2
Water,	4.8
Salt of lime, magnesia, and potash,	8.5
Loss,	4.6
	100.0

HENRY'S ANALYSIS.

	Light.	Sound.	Worm-eaten.
Resin,	12	9.6	* 14.4
Extractive,	15	25.0	25.0
Starch,	19	20.4	20.6
Woody fibre,	54	42.0	40.0
	100	100.0	100.0

S. PERCY'S ANALYSIS.

False Jalap condemned by Drug Examiner.	Good officinal.	Very fine on string.
First. Second.	First. Second.	
Resin,	4 2	17 14
Extractive,	9 8	19 24
Starch,	11 15	18 21
Woody fibre,	76 74	46 41
	100 100	100 200
		100

It will be seen by these analyses, that the amount of resin in true officinal jalap varies very greatly, being as small as 9.6 in an analysis made by Henry, and as large as 23 in an analysis of a very superior quality of root, made by myself. The United States Government requires that no jalap shall be imported that does not yield 11 per cent. of

AM. MED. TIMES, VOL. IV., No. 24.

resin. It will be seen, in the analysis given by Henry, that the worm-eaten jalap yielded a larger amount of resin than the other samples, and, therefore, it has since been argued, and universally taught in the books, that worm-eaten jalap was to be preferred for making the resin; but this is false reasoning, and is not according to facts. I will grant that the worm-eaten jalap is generally very dry, and, therefore, should yield a larger percentage than the same weight of root that is moist; but that the worms eat the starch, as it is alleged, and leave the resin, is all fiction. Years ago I tried a number of experiments to settle this question. I divided whole roots of jalap, and weighed them accurately, keeping one-half in a tightly closed jar, and putting the other half with jalap that was infested with worms until it became worm-eaten, and lost from six to fourteen per cent. in weight. This latter would powder much more easily than that kept in a jar, and when exposed to the drying box lost less in drying, but the percentage of resin, in an equal weight of the dried powders, varied but a mere trifle. The results were alike in three such experiments. You can draw your own inferences as to whether it is better to purchase a good sample or a worm-eaten one; but if you will visit the drug mills you will find that in jalap and many other substances, the age of administering worms in powder has not entirely passed away. It will be plainly seen, by comparing the analyses of Henry, that the worm-eaten root was originally the best jalap, as it contained, even after it was worm-eaten, a large amount of starch and a much less amount of woody fibre than the other samples.

In the analysis that I have given above of false jalap, I am happy to say that a very large quantity that came to this port was condemned by the Drug Examiner. The small amount of resin that I obtained from it was not purgative in doses of two grains. The last analysis given was of small selected roots, sliced in uniform-sized pieces, and put on strings to dry. I have seen but few such samples in the market.

Method of Preparing the Resin.—There are a great many formulæ for the preparation of this article, but the one I prefer is a modification of that of Christison. Into a glass or earthen displacement apparatus a layer of animal charcoal is introduced; upon this, coarsely powdered jalap, mixed with about one-half its bulk of animal charcoal, is placed. The whole is moistened with alcohol (eighty-six per cent.), and allowed to stand for twenty-four hours; percolation is then allowed to proceed, and fresh alcohol added until the percolate precipitates but little resin upon being dropped into water. The whole of the percolate is mixed, and the alcohol distilled off at a low heat until two-thirds of the alcohol have passed over. The residue is then slowly poured into cold water, from which the resin separates. It is then thrown upon a stretched strainer and washed with water, and dried. It may be kept either in rolls or powdered.

When thoroughly dried, this resin is nearly all soluble in alcohol; it is insoluble in oil of turpentine and fixed oils. It is soluble in alkaline solutions. A portion only is soluble in ether, amounting to 25 to 35 parts in 100. This portion soluble in ether is called the Soft Resin, while that part insoluble is the Hard Resin, or the Jalapin of Hume. A peculiar change takes place in this resin of jalap after it has been subjected to the action of ether. In a very interesting essay written by Mr. John Long, in the *Am. Jour. Pharm.*, vol. xxiii., p. 487, "On the Resins and Aqueous Extract of Jalap," he here states that after exhausting the ordinary resin successively with cold and boiling ether, which abstracted 32½ per cent. of soft resin, the residue "was treated with several portions of alcohol 95 per cent., both hot and cold, but was found to be only sparingly soluble in that menstruum, entirely soluble in diluted alcohol and boiling water;" and he repeated the experiment on medicinal resin, carefully prepared on a previous occasion, with like results. I have repeated these experiments of Mr. Long's, and find they are correct.

As I have before stated, a large quantity of the commercial resin is but of about double the strength of jalap

powder, and is prepared by making an aqueous extract, and mixing it with the resin. Although jalap root, when treated with water, does yield a portion of its resin, this resin is wholly absorbed from the aqueous extract by alcohol, and the residuum is quite inert. The resin taken up from this aqueous extract by alcohol is purgative in an equal degree with that prepared by alcohol as above directed. They are both hydragogue cathartics in doses of one to four grains. The soft resin extracted by ether is rather more active than the two resins combined, the hard resin being, in my experience, rather slower in its operation than the soft, and not so apt to gripe. The aqueous extract, if prepared from fresh jalap root, is slightly purgative, but if made after the extraction of the resin by alcohol, is quite inert. The addition of the aqueous extract to the commercial article is therefore fraudulent. Mr. Bullock has found a sample of "hard resin of jalap" in the market, which owed all its medicinal activity to 34 per cent. of resin of gamboge.

Professor Proctor (*Am. Jour. Pharm.*, vol. xxix., p. 108) gives a formula for the preparation of a fluid extract of jalap, which is intended to be a solution of the resin principle formed into a soap with carbonate of potash, and sweetened with sugar. His formula is a hydro-alcoholic fluid extract of jalap root, containing the strength of a fluid ounce of the root thus extracted in one fluid ounce of extract. It is in my opinion liable to two objections—uncertainty in its action, and unpleasantness of taste—both of which may be obviated to a great degree by using the resin in place of the jalap root. We have shown, by a number of analyses, that no two samples of jalap root contain the same amount of resin; we therefore have with every different sample of the extract a difference in strength. The hard resin does not possess a very unpleasant taste, nothing like the nauseous taste possessed by the hydro-alcoholic extract. I have, therefore, been in the habit of using the following formula in preference to that of Prof. Proctor:—Take of the hard resin of jalap, 384 grains; carbonate of potassa, 2 drachms; sugar, 4 ounces; diluted alcohol, sufficient to make the whole 8 fluid ounces. The resin is rubbed in a porcelain mortar with a portion of the diluted alcohol and the carbonate of potash; the balance of the diluted alcohol and sugar are then added. The mortar is placed on a sand bath, and heat applied until the sugar is dissolved. Each fluid drachm of this extract contains six grains of the resin, the maximum dose required; and the dose may at all times be easily calculated, as each minim contains one-tenth grain of resin. This has but little taste, but it can be further disguised by adding a little essence of anise-seed or ginger. This resinous soap of jalap is less irritating, and less apt to gripe, than the resin administered without the combination of an alkali.

Of the pathological effects and therapeutic application of jalapin, we need say nothing in this place, as we most thoroughly discussed them in our lecture upon Jalap.

In the *Oporto Medical Gazette*, Dr. Caucellas describes a case of poisoning by arum maculatum. A healthy child, three years old, while playing about, met with a basket containing the flowers, fruits, and roots of the plant, which had been collected for the benefit of the pigs after boiling. The child chewed and ate some of them; and, on returning to his parents, complained of burning in the lips and mouth. When seen by the doctor, the child was in a state of prostration; he did not speak, but often raised his hands to his mouth and throat, and occasionally uttered a piercing cry, rising up as if suffocated. The lips, the palate, the tongue, the amygdale, pharynx, etc., were swollen; and pain at the epigastrum was felt on pressure. He could not swallow, and died asphyxiated during the night.—*Brit. Med. Jour.*

AMONG the Representatives from New York devoting much time to the sick at Washington, is Mr. Wall, of Brooklyn, who donates to those wounded in battle all the compensation he receives as a member of Congress.

Original Communications.

REPORT OF THE MILL CREEK HOSPITAL, FORTRESS MONROE.

BY FREDERICK D. LENTE, M.D.
OF GOLD SPRINGS, NEW YORK.

THE Hospital, which is a temporary wooden structure about two hundred and fifty feet in length, by about sixty in breadth, and sixty feet high at the greatest elevation, is situated on the Peninsula, about a mile from Fortress Monroe. There are at this time no partitions, and the one ward is no doubt the largest in the world, containing two hundred and fifty beds.

I opened the hospital by order of Dr. John M. Cuyler, Medical Director, on the 11th of May. The wounded, who had arrived the previous night from Williamsburg, were rapidly brought in by the ambulances. Most of them had received little or no surgical assistance since the battle, nearly a week before, as they were during all that time *in transitu* by ambulance or transport from the battle-field. But few operations had been performed.

I divided the building into four *wards*, which were separated merely by the aisles, running lengthwise and crosswise, and intersecting in the centre of the building. The beds were then arranged in sections of twelve each; each section having two rows of six each. There were twenty-two sections; and, as the nurses were relieved every six hours, it was necessary to have forty-four nurses, that each section should have one. Each ward had a *ward master*, and, when practicable, was also supplied with two extra nurses for following the surgeons during their rounds. The nurses were supplied by detailing soldiers from the regiments encamped near by; and one of the greatest annoyances I had to contend with in organizing and managing the establishment, was the frequent change of nurses; as, each day, some of them would be recalled to their regiment, and a new set detailed. This is a very serious evil in the military hospitals, and might, apparently, be easily remedied by *enlisting* a certain number of men as *nurses*. The soldiers were generally very *willing*, very respectful, and attentive; but, necessarily very ignorant of their duties, requiring incessant watchfulness and instruction. To prevent confusion as far as possible, in an apartment containing, during most of the day, some three hundred souls, patients, nurses, surgeons and assistants, visitors, etc., etc., all strange faces, I marked the nurses with red badges, the assistant nurses with white, the ward masters with yellow. By this some approach to order was secured.

The *wounds* were mostly made by musket balls and buckshot. When a bone was implicated, it was generally shattered into numerous fragments, which were, in many cases, driven far and wide among the surrounding soft parts. When the bone had been struck by a minié rifle ball, it shattered it at the seat of the wound, and then split it up and down for some distance. There were only two bayonet wounds, and but few shell wounds. Many wounds were apparently made by a flanking fire, as the balls perforated the arm, and either the walls of the chest, or the muscles of the back, making four openings, or passed through both thighs, except when the bone was struck.

I have been able to classify 214 cases, with regard to the *seat* of the wound. There were—of the *foot*, ten cases; of the *hip*, thirteen; of the *knee*, some involving the joint, and some the bones forming the joint, eighteen; of *lungs*, five; *walls of the chest*, eleven; *leg*, thirty-eight; *thigh*, thirty-six; *shoulder*, twenty-one; *genitals*, six; *skull*, three; *neck*, five; *face*, nine; *spine*, one; *arm and forearm*, seventeen; *hand*, six; *back*, three; *walls of abdomen*, seven; *abdomen*, five.

Six of those wounded in the *thigh* were also wounded elsewhere, some in more than one situation; four of those of the leg, five of the genitals, the wounds generally involving the buttock or thigh, five of the hip, five of the arm,

two of the walls of the abdomen, five of the shoulder, three of the walls of the chest. In some cases, there were four, five, or six different wounds, and yet the patients doing well. Many of the arm cases were very severe, necessitating amputation at the shoulder-joint, or extection of the joint or shaft. The wounds, generally, in this and the other hospitals, were difficult of management—more so, Prof. W. Parker remarked, than any he had seen.

On admission, the wounds involving bones, and through the knee, and the few stumps, were in a very unfavorable condition. Of the flesh wounds, although generally of a complicated and severe character, most of them were in a good condition, and continued to progress remarkably well; water dressings being generally used. The wounds of the lungs did well; the patients suffering from them, had all expectorated more or less blood at first, but it had ceased when they entered the hospital. In one case, the ball entered at the lower part of the right lung, and emerged above the spine of the scapula, perforating the lung from bottom to top. The man suffered for a few days with pain and cough, and required the use of anodynes, but subsequently did well. It would seem from the experience of this hospital, and I believe the same remark would apply to the other hospitals, as far as I could learn, that a gunshot wound of the femur is far more dangerous than one of the lung. If, however, the ball should pass directly through the rib, shattering it, the case would be much more serious. In one of the two fatal cases, the ball passed directly through the middle of the sternum. One interesting feature of the gunshot wounds was the frequency of secondary and of recurrent haemorrhage, and its obstinacy. This is not so remarkable in military surgery; but it is not so common to have, as we did frequently, secondary haemorrhage in cases where the amputation, or other operative procedure, was done through perfectly healthy parts, at a distance from the track of the ball. In the first operation performed in the hospital, the ball had passed below the knee, and the advice of more than one surgeon was to amputate at the joint; but, fearing a subsequent sloughing of the posterior flap, I decided to go above the knee. Yet this man died on the sixth day of secondary haemorrhage. The haemorrhage, in all the cases, occurred before the period of ulceration of the ligature through the arterial coats. It is to be regretted that *post mortem* examinations of the stumps were not made, but it was utterly impossible without neglecting the urgent wants of the living. The matter was, however, afterwards discussed with several distinguished surgeons, to whose attention I brought the subject.

Dr. W. Parker had occasion to examine one case where death occurred from haemorrhage after both ends of the wounded femoral had been tied by Dr. Bontecou in the Hygeia Hospital. He found the portion of artery between the ligatures sloughy, and that the slough had extended above the upper ligature, thus causing the fatal haemorrhage. A similar instance has fallen under his notice during the present war. The general opinion was that the haemorrhage is, in most cases, due to sloughing of the artery above the ligature, and that the sloughing is due to a depraved condition of the patient's blood, brought on by unfavorable hygienic conditions before and after the battle. Let us briefly examine what these conditions were. For some weeks before the army of the Potomac moved from that river, the men had been exposed to a great deal of rain and dampness; and for four weeks after they landed in the peninsula, they were more or less wet day and night, the rain scarcely ever ceasing; added to this, the labor which they performed must have been prodigious.* And, amid so much rain and mud, with the necessity of avoiding fires as much as possible, it is to be presumed that the proper cooking of food could not have been systematically attended to. Finally, a forced march through deep mud on the heels of a flying enemy, to Williamsburg, then an attack

under a pelting rain, on the entrenchments, and a hard fight of several hours, then the wounded lying for some hours in the mud and rain, then jolted over horrible roads to the York river; then, after further delay, crowded on transports, where they could neither get suitable food nor proper surgical attendance, then the trip down the river, then another transference to ambulance, and conveyance a mile further to the hospital. Fatigue, loss of blood, loss of sleep, starvation; for such food as could be served under these circumstances was not that which the severely wounded could eat. Is it to be wondered at that the blood of these patients should have been dark, thin, diffluent, and defibrinated? But few operations had been performed on the field; and the bad cases, those of compound fracture especially, were in an exceedingly unfavorable condition for operation when admitted. The battle was fought on Monday, and they were admitted into the hospital on the Monday following. The limbs were in many instances greatly swollen, infiltrated, and discolored. In some cases, to wait was certain death—a painful, lingering one. To amputate was almost equally certain to insure death, but there was a forlorn hope, with a brave and hopeful patient, of saving life; and if death should ensue, it was a speedy and painless one. Once, I amputated close to the hip-joint in such a case; the patient died on the table soon after the completion of the operation, never recovering consciousness after inhaling the ether. Once, Dr. Alden March did the same in the lower part of the thigh, with a fatal result, a little less speedy. In many of the less desperate cases, where secondary haemorrhage did not necessitate immediate operation, we waited in the hope that the general condition of the patient would be improved by the better hygienic conditions in which he was placed, and by the better food and nursing. But the local condition continued to grow worse, and if the patient rallied a little at first, he soon reached a point beyond which he could not be raised, and he then began to sink again. And we can hardly wonder at this, when we reflect on the conditions of the wound—a bone shattered into numerous fragments, and often split upwards and downwards almost to the adjacent joints, especially when conical ball inflicted the wound; these fragments often driven into the surrounding muscles. This was the condition of most of the cases in which we amputated, and extected. Dr. Macleod, in his "Notes on the Surgery of the War in the Crimea," well describes the condition of these wounds when left to take care of themselves—"I myself examined the limbs of a large number of men who died at Scutari during the early part of the war, and, in not a single instance almost, did I observe the slightest attempt at repair; but, on the contrary, invariably found a large sloughing chamber filled with dead and detached fragments of bone, shreds of sloughing muscle, and destroyed tissue, into which the black and lifeless bones projected their irregular extremities, and across which, lying in every direction, but seldom in the axis of the limb, were dead and detached sequestra, the 'fracture-splinters' of the accident." What was to be done with these cases under the circumstances? Clearly, one of two things—either amputate, and remove a source of irritation at once, or make a large incision, remove all foreign bodies, as splinters of bone, balls, etc., saw off the jagged ends of bone if expedient, put the limb in as immovable a position as possible, and hope for subsequent approximation of fragments, and a restored limb. Both these expedients were frequently resorted to. Extinction of the continuity of the femur, of the os brachii, and of the shoulder-joint, were liberally practised in the different hospitals. This was strikingly the case in the general hospital under Dr. Bontecou, where a large number of extections were performed; the results of which, it is to be hoped, he will one day give to the profession. My connexion with the hospital ceased before the results of all our cases could be ascertained; but very many were fatal, especially the amputations; secondary haemorrhage, sloughing, and exhaustion carried them off. *Pyæmia* was very rare, and we

* If any one wishes to form some idea of it, let him visit the vast roads, entrenchments, batteries, etc., stretching for miles in front of Yorktown, which General McClellan constructed in about three weeks' time.

had only one case of *tetanus*. To quote again from Macleod—"The depressed condition of body to which the hardships of war had reduced the men, made a severe compound fracture of the femur synonymous with death." I must quote still further from Dr. Macleod's language, so descriptive of what I myself noticed. "Many of our patients looked very well at first—appeared perhaps strong enough, and expressed such a confident hope in the result, as almost to deceive their surgeon. The injury might not appear very severe; the bone was undoubtedly broken, but it might not be much comminuted; and thus we flattered ourselves, and began a trial hopefully, which always ended in disappointment. The golden opportunity was allowed to pass, and so we entered on a road which led to death, whether through the portal of amputation or any other. The struggle soon began; suppuration set in. The disease which lurked in the 'blood and bone' showed itself."

Now, it may be asked, in view of the utter helplessness of these cases when left to themselves or to secondary operations—Whether it would not have been far preferable to have operated on the field, or as soon after the battle as practicable? If the worst cases had been amputated, and the more favorable cases of compound fracture incised freely, and the loose fragments of bone and rough ends removed, and an extemporized splint placed on the limb, it is certain that the journey would have been far better borne, and probably the wounds in a far better condition. Says John Bell, "it is less dreadful to be dragged along with a neat, amputated stump, than with a swollen and fractured limb, where the arteries are in constant danger from the splintered bones; and where, by the least rude touch of a splinter against some great artery, the patient, in a very moment, loses his life." The wounds of the knee-joint, especially, should have received earlier attention, as they are the most fatal of all, according to the large experience of the Crimean war. They were in a dreadful condition when admitted; the treatment pursued was generally to make a free opening on either side, and remove the ball if it had not made its own way out, and make a free outlet for the unhealthy discharge. But the cases, as usual, progressed unfavorably. At the present day, there seems to be a disposition to sacrifice too many lives at the altar of conservative surgery. Long ago such was the case; but nearly all the great authorities in military surgery finally came to the unwelcome conclusion, that to save life the limb must be sacrificed. It was found that, in the very cases of compound fracture of the femur where the patient survived, it was only to suffer from tedious necrosis, and abscess, and exfoliation, and to drag a comparatively useless limb after him the rest of his life, or finally to submit to amputation as a less evil. If such were the unpleasant experiences of the days of spherical balls—of Bégin, of Ribes, of Larrey, of Guthrie, of Hennen, of Dupuytren, of the French surgeons in the Crimea, according to the testimony of Macleod, how much more likely is it to be our experience with the terrible minié bullet?

A branch of Conservative Surgery, which might be more extensively cultivated by surgeons, is, the *prevention of all unnecessary loss of blood* in all operations, but especially in those pre-eminently designated *conservative*, large incisions about the joints, or along the shaft to remove fragments, or to resect. When the patient is already exhausted by hemorrhage, and other unfavorable circumstances, the additional loss of an ounce or two of blood might turn the scale against him; and it is certain that several ounces are often lost in these operations from small vessels before they retract and are plugged up by the saving clot. Now, without the delay of a minute or two, half-a-dozen of the little ingeniously contrived serrefines might be put on to as many spirting arteries, and by the time the operation has been completed the clot has formed, and they may be removed. A general order insisting on the use of these little auxiliaries would save more lives and limbs than that which urged the substitution of exsection for amputation.*

* In a new "field case," and a very excellent one, just arranged by Dr. Gilbert of the army, he has included a number of these little instruments.

Those wounds treated in the Mill Creek Hospital, which did not involve fracture of the large bones, or injury of large arteries, that is, a very large majority of all admitted, although many were complicated and severe, were progressing remarkably well: about fifty had so far improved at the end of a week as to be transferred to a transport for conveyance to convalescent hospitals. During the first week only twelve deaths occurred. The ventilation of the building was almost perfect; in this respect, superior to any of the other hospitals; and, amid all the confusion and inconveniences incident to a hospital of this character, special attention was paid to the nutrition and comfort of each patient, a liberal supply of all necessaries, and many luxuries, having been furnished through the energy of the medical director, Dr. Cuyler, who merits the warmest gratitude of the thousands of sick and wounded who have passed under his supervision, and the devoted kindness and liberality of Mr. Barclay of Philadelphia, and Mr. Hayward of the Sanitary Commission.

This paper has, under the circumstances, necessarily partaken largely of a rambling and desultory character, and has extended itself to rather an inconvenient length, I fear, for your Journal. I had intended to notice the triumphant success of *sulphuric ether* as an anesthetic in military surgery, as far as it was demonstrated in the Mill Creek Hospital, where no other anesthetic was used, at least during my superintendence. But it must be deferred to another time and another paper.

COLD SPRING, June 2, 1862.

REMOVAL OF A TUMOR

INVOLVING THE PAROTID AND SUBMAXILLARY GLANDS;
DESTRUCTION OF THE TEMPORO-MAXILLARY ARTICULATION;
REPRODUCTION OF JOINT, AND
CURE OF PATIENT.

BY E. S. COOPER, A.M., M.D.,

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THE UNIVERSITY OF THE PACIFIC, SAN FRANCISCO.

SOME of the more prominent features of the following case were given in the *San Francisco Medical Press* during the progress of cure. I now give it in detail.

Case.—Miss S. F., age 14, was admitted into the Pacific Clinical Infirmary, in consequence of an enlargement of two years' standing, involving the parotid and sub-maxillary glands. The tumor had grown internally until it almost filled the fauces, giving rise to great difficulty in both deglutition and respiration, and these difficulties were rapidly increasing. The tumor was nodular, and very hard on the outer side. The ramus and angle of the inferior maxilla were pressed out of their places over an inch. The face was prodigiously deformed, the length of the tumor from the outer to the inner side being over three inches.

Operation, April 20, 1861.—The operation was commenced by ligating the common carotid artery above the omo-hyoïdes muscle. An incision was then made commencing at the upper part of the one made for ligating the artery, passing directly in front and terminating one inch above the ear. A large long flap was then dissected forwards, exposing the exterior of the tumor, which was soon found to involve not only the parotid and submaxillary glands, but all intervening tissues.

The tumor being now found so much enlarged on the inner side of the jaw that it was impossible to remove it without either cutting away the ramus of the jaw or otherwise detaching the masseter, temporalis, and pterygoid muscles, disarticulating the temporo-maxillary joint, and drawing the jaw forwards to make room for extracting the tumor, the latter method was adopted. The masseter was first cut away from its attachment to the zygomatic arch with the scalpel, after which a chisel was used and the ligaments concerned in the temporo-maxillary articulation divided. The attachments of the other muscles were also removed with the chisel, after which that side of the jaw, being set free, could readily be moved forwards to a con-

siderable extent. The detaching of the muscles from the bone also destroyed the adhesions of the tumor to it, which were firm on the inner surface of the back portion of the ramus. This part of the bone had been absorbed by the pressure of the tumor until it was as thin as paper.

The manner of removing these attachments with the chisel may require explaining, since the instrument is seldom or never used by others for this purpose, but it is a most excellent means of detaching the soft parts from the bones in any part whatever. It is used as follows:—The handle being held steadily in the hand, the edge is pressed close to the bone and moved in different directions, being constantly upon the watch that the instrument is kept between the bone and the soft parts containing any important tissue. To be more explicit; there is always a little space between the bone and important blood-vessels and nerves in the different regions of the body, and by keeping a cutting instrument directly in contact with the bone these can be avoided. Then, as the chisel is the proper cutting instrument for the case, its edge should be carried close to the bone with a sort of gliding motion.

The soft parts being cut away from the external surface of the tumor, it was pried out with the chisel, the attachments of the parotid gland to the deep-seated parts being exceedingly fragile and easily overcome. This difficulty, however different from what usually occurs in removing the parotid gland, was the easiest part of the operation.

Having now the posterior part of the tumor detached, and the side of the jaw movable forwards to a considerable extent, I could introduce my finger sufficiently under the angle and ramus of the jaw to seize the major portion of the tumor, and draw it outwards and backwards. This being done somewhat forcibly, its attachments to surrounding parts were shown and divided until the tumor was removed. The whole operation occupied three-quarters of an hour.

The tumor weighed seven ounces and two drachms. It was of a fibro-cartilaginous character, and had a calculus in the centre. Whether this was formed first in the parotid gland, and was the cause of the tumor or the product of it, I am unable to say. The diseased mass was completely encysted, except where it was adherent to the ramus of the jaw. This condition of the tumor aided greatly in its thorough removal.

Fortunately, the mucous lining on the inner surface of the tumor was not broken, and the hemorrhage, which was slight, from the recurrent circulation was all discharged through the external wound.

The patient rested well during the following night, and on the next day called for nourishment, which in liquid form was swallowed without inconvenience, and the little sufferer found herself in every way comfortable.

The after treatment consisted in the application of a piece of lint over the wound, which was closed by five sutures at equal distances from each other, and a roller around the head and over the chin, as is applied in fractures of the lower jaw. This whole dressing was kept wet in an evaporating lotion composed of one part of alcohol and ten of water. The evaporating lotion was applied every half hour, and continued for seven days, when it was discontinued, and poultices applied instead.

The major part of the wound made for ligating the carotid healed by first intention. The stitches in the upper part of the wound sloughed out in about ten days, so that the external surface of the ramus of the jaw was again in view, also the temporo-maxillary articulation; and at the end of two weeks the major portion of the exposed bone became covered with healthy granulations, so that the margins of the wound were approximated in order to promote the more rapid closure of the wound, which had rather been prevented previously until the condition of the bone was found favorable. During the operation, in breaking up the attachments of the muscles to the jaw, the periosteum was necessarily removed in several places, so that it was necessary to keep the bone in view until all was

found to be right with it. In destroying the temporo-maxillary articulation, the articulating face of the condyloid process was injured, and I was unwilling to let the soft parts close over the joint until everything was healthy in or about it; and having long since discarded the idea that air admitted into joints is a source of irritation, or even of the least injury, I saw no objection to having the joint exposed to any reasonable extent.

Matters progressed very kindly, and at the end of seventeen days the commencement of the re-formation of the external lateral ligament could be distinctly noticed. In two days more, one could notice a fibrinous deposit connecting the condyloid process to the margin of the glenoid cavity, although it was so fragile that it would constantly break when the jaw was moved somewhat briskly, but soon attained strength enough to withstand the motion.

Sloughing of Bone.—A portion of the posterior surface of the ramus, and all the articulating face of the condyloid process sloughed, and was discharged at the end of seven weeks after the operation.

July 26th.—The wound is nearly entirely cicatrised, the motion of the lower jaw being almost perfect, and the deformity of the face comparatively slight.

Sept. 7th.—Improving in every respect. The wound is almost entirely cicatrised, and that over the temporo-maxillary articulation entirely so. This joint is so perfectly reproduced, that no one by looking at it simply could form an idea that it was ever interfered with further than was indicated by the cicatrix over it.

Jan. 10th, 1862.—The patient recovered in every respect, save the deformity caused by the cicatrix, and the loss of nervous power consequent upon the division of the pes anserinus, leaving that part of the face partially paralysed. This condition was constantly improving, and the tone of the parts had been so far regained that, when the mouth was quiet, no want of symmetry in the contour could be discovered on the two sides of the face. The little girl left the Infirmary to-day in excellent health and spirits, having gained seventeen pounds in weight since the operation.

EXPERIENCES IN THE PRACTICE OF MILITARY SURGERY.

BY DAVID P. SMITH, M.D.,

BRIGADE-SURGEON, AND MEDICAL DIRECTOR OF GEN. THOMAS'S DIVISION.

I DESIRE first to call the attention of the profession to amputation at or just above the knee-joint. I have performed this operation five times among the wounded at Mill Springs, and at Shiloh. In the first case, an amputation in the upper third of the leg, performed on the field by some very hasty person, to say the least, had resulted in sloughing of the flaps and protrusion of the bones. In the second a gunshot fracture of the tibia had reduced the bone to such a state of comminution that recovery was not to be hoped for, especially as the minie ball was not extractable. In the third and fourth cases, a similar state of things existed. And in the fifth a minie ball, entering between the inner hamstring and vastus, and passing inside of the popliteal vessels, had sunk deep into the posterior, inferior, and inner face of the outer condyle of the femur: from its bed it could not be extracted, even after the limb was removed, without an enlargement of the cavity; merely cartilage intervened between it and the cavity of the joint, and at the time of the operation, seventeen days after receipt of injury, softening of the bone and inflammation if the joint had proceeded to a great extent.

In three of these cases I made a circular incision perpendicular to the axis of the limb, at the height of the middle of the patella; then, dissecting up and turning back the skin to the width of four fingers, circular incision was made through the little muscular and more cellular tissue, and bone sawn just as it expands to form the condyles. This procedure, which I had often practised upon the cadas-

ver at Clamart, affords the proper amount of flap. If you save more skin it is redundant.

In two cases, where the tibia had been smashed too high up for amputation in continuity, I made lateral skin flaps, by commencing my incision just on the middle of the patella, carrying it first downwards, then curving it across the limb, and terminating it just in the middle of the popliteal space, exactly opposite the point of commencement; thus forming a lateral skin flap of about five inches in length, and of a base equal in diameter to half the circumference of the limb. A similar flap being made upon the opposite side and dissected up, disarticulation may be done, and the artery divided at the very last, if thought best. Flaps of these dimensions will neatly cover the expanded condyles after dissecting out the patella, which had better be done after the raising of the skin flaps; but to do away with the irregularity of joint surface I prefer to saw off half an inch in thickness of the cartilaginous surface of the stump. I think no one who tries this operation will regret it. This also I worked out on the cadaver. The artery, vein, and nerve, are far out of harm's way, and drainage of the stump is perfect.

II. I had two cases on board of the Crescent City, that I had charge of, and ran up to St. Louis, full of the wounded from the battle-field of Shiloh, which to my mind showed that the risk of amputation at the hip had been greatly exaggerated. Two men were brought on to my boat from the battle-field, where they had lain without succor for three days with terribly shattered femurs. In each case the minié bullets had struck the bone when the knee apparently had been raised, thus causing oblique impact of the ball, and destruction of the bone for at least six or eight inches.

I advised amputation at the hip in each case, on account of the fracture being high up, and the soft tissues being much infiltrated. The gentleman to whom I assigned one case, however, preferred to amputate just below the trochanters. A little delay was unavoidably caused by the many fragments of bone, and a few hours after the operation, which was most skilfully done, the man died. In the other case I amputated at the hip-joint. After I had transfixed to form the anterior flap, and had cut down about four inches, Brig.-Surg. H. P. Stearns, of Hartford, Ct., dexterously slid in both of his hands, and compressed the arteries so accurately that on completing the flap no hemorrhage followed. Disarticulation was rapidly effected, and a straight cut made down through the glutei muscles, so as to leave as little surface as possible to the posterior flap. The arteries in the posterior flap were tied first; I then made haste to tie the femoral and profunda, which had been perfectly controlled by my able, assistant. Not more than six ounces of blood were lost in the whole operation, and but little time was occupied. The operation was done on Sunday. The following Monday he was taken on shore to one of the hospitals in St. Louis. The last that I heard from him was that on Thursday he was still alive. I have taken measures to hear further from him. It may be a successful case.

As to the result of my amputations at the knee-joint I am sorry that I cannot inform the reader. We have been so constantly on the march that it has been impossible for me to follow up the result of the cases.

In each case, however, the appearance of the patient was far better than in the case of those who had had amputation performed higher in the thigh.

III. I ligated the femoral artery in Hunter's canal in two cases, in which secondary haemorrhage occurred from gun-shot wounds received at Mill Springs.

In the first case I was called at midnight, and found profuse haemorrhage proceeding from an aperture of entrance between the inner hamstring and vastus of the right leg. A tourniquet, which had been applied to prevent immediate dissolution, was of but little avail. Ordering it removed, I inserted the forefinger of the left hand into the wound, which but just admitted it, and feeling the warm

gush of blood, controlled it by pressure against the bone. Then, obtaining additional light, I made an incision both upwards and downwards from the wound, and slitting up the tendinous canal, exposed the artery, and tied it both above and below the ulceration into it. Then scooping out the clotted blood, I found the unextracted minié ball lying close behind the femur. This operation was done on the fourteenth day after receipt of the wound. The wound was lightly dressed, and the patient expressed much relief. Everything went on favorably until the third week after the operation, when a wasting diarrhoea sent in and carried off the patient.

The day after my operation upon the preceding case, my attention was called to the following one:—A small wound of entrance existed just over the inner surface of the condyle of the femur. The surgeon in attendance had not been able to pass a probe into it to any depth, and thought that the ball had rebounded from the spongy condyle. The man had just begun to complain of severe pain in the calf of the leg, and the limb was beginning to swell. No hemorrhage occurred from the wound. Early the next morning the limb was found a good deal enlarged, and pain was severe. My diagnosis was ulceration through the coats of the popliteal or femoral artery, and consequent infiltration of the calf; I then raised the margin of the round wound over the point under which the shot must have passed had it injured the artery. Then directing a probe in the same inferred direction, it readily passed into a large cavity: still no bleeding. I cut upon the probe, and found that it led right down to Hunter's canal. A gush of blood coming, I ran my long bistoury up and down; in an instant had scooped out the coagula with my two palms, and in another instant had my finger on the artery at the ruptured point. Here again I tied above and below the opening. It was curious to observe the coagula slowly oozing up from the calf and out of the wound. The tissues in the popliteal space were greatly disorganized.

Here no reparative process took place; no granulations formed in the wound; the extremity became gangrenous; a diarrhoea, which he had had for months, increased, and he sank. This operation was done on the sixteenth day after receipt of the injury.

IV. I wish next to call attention to two cases of exsection of the shoulder-joint, that a little comment may be made upon some points. Had I been upon the ground I should have advised the performance of these operations soon after the receipt of injury. As it was, the operations were not done until, in the one case the 17th, and in the other the 19th day after the battle. In both, I made a simple straight incision down through the deltoid to its insertion. In these cases the bone being in fragments, deprives you of all leverage; however, the incision I speak of enables you easily to pick out the fragments and disarticulate. It is difficult to convey an adequate idea of the destruction or *devastation* done by the minié balls in these cases. Large and small, needle and chisel-shaped fragments of bone had been driven, just as if the bullet had been a minute shell and had exploded in the joint, into all the surrounding soft tissues. By the continued irritation—"ubi irritatio ibi fluxus"—the parts had become gorged with blood, which oozed forth abundantly upon every disturbance of the fragments. With all this oozing of blood there were spicula to be dragged out from the muscles and from direct contact with the axillary artery, vein, and nerves, which were imbedded like arrows shot into the parts, all making these the two most unpleasant operations I ever did. The sooner after the receipt of injury these exsections are done, the more fortunate and perfect will be their results. One of these cases died from *pyæmia*; the other did well. Two months after the operation, I heard that the wound had nearly closed, and he was beginning to use the arm.

V. In two instances, I removed a large amount of fragments from the shaft of the humerus, in each instance equal to at least two and a half inches of the entire shaft. In each of these cases it was the finger alone, introduced as a

probe, that conveyed any adequate idea of the extreme comminution of the bone. Indeed, in military surgery it is, in almost every instance, folly to place any reliance upon or attempt to gain accurate information with an ordinary probe. In these cases, too, the *dispersive* effects of the minie ball were clearly shown, for, not only were fragments of bone driven into all the surrounding tissues, but in one case, where the ball infringed just below the insertion of the deltoid and passed entirely through from the front, I found by my finger a fragment driven into the elbow-joint from between the coronoid process of the ulna and the articulating facet of the humerus. About two months after these operations, I heard that the arms had become rigid and were being used. I mention their having become rigid because I thought there was much danger of false joint, inasmuch as the exsections had occurred at the favorite place for that complication.

VI. The bullet forceps of Tiemann & Co., New York, deserves particular and extended notice. It has time and time again enabled me to extract bullets, that all other forceps had failed to move. I am not extravagant when I say that, in comparison with it, none other is worthy of the name bullet forceps. Indeed, I can truly say that, among the endless variety of instruments that I brought home from the Old World a year ago, I have not one for any purpose so triumphantly perfect as this bullet forceps of Tiemann.

Reports of Hospitals.

BELLEVUE HOSPITAL.

REPORT OF CASES OF MENINGITIS TREATED WITH IODIDE OF POTASSIUM.

[Reported by F. R. LYMAN, M.D., House Physician.]

CASE I.—Ann Gammon, married, native of Ireland, at. 39. Admitted Sept. 24, 1861, with a child seven months old (service of DR. FLINT). Her history was obtained from her friends.

History.—Patient is generally healthy, of temperate habits; has had otorrhoea since childhood, the discharge ceasing about three weeks previous to her illness. Thursday, Sept. 19th, complained of headache all the morning; at 9 A.M., on going up stairs this pain suddenly became intense, and she was obliged to sit down. She screamed with the pain, which she described as going through her head like a knife, and then fell into a comatose state, from which she could not be aroused. At 10 A.M., an hour later, she began to vomit, which she continued to do at intervals until the 22d. She was roused partially from her stupor, so as to show that she heard any one who spoke to her suddenly, and with a loud voice. Several doses of oil and other purgatives were administered, but not retained. Enemas were given, but without causing a movement of her bowels.

Symptoms on Admission.—Patient lies in a semi-comatose condition, rouses up when called by name, replies to questions slowly and with a thick voice. Pupils contracted, but they respond to light; has photophobia; tongue large, thickly coated with a white fur; pulse 72, hard; extremities cold, indicates her head as the seat of her trouble; bowels not opened for over a week, according to her friends. Ordered, B. Ext. colocynth. co., gr. v.; ol. tiglii, gtt. j.; M. ft. pil. Sinapisms and frictions to extremities.

25th Sept., 9 A.M.—Patient in same condition. Bowels freely opened; had a very large black dejection. Ordered blisters to nape of her neck and temples. 26th.—Pulse 100, and of a jerking character; has slept some; the cornea has become less, and she answers questions more readily. Dr. Flint ordered pot. iod., gr. v., three times a day. There is a partial paralysis of the left arm to-day, and her mouth is drawn to the right side. The sensation and motion of the left arm are very much affected. Lower extremities

are normal. 27th.—Patient for first time asks where she is, and about her children. Complains of the loss of power in the left arm. Has pain in head yet; says she does not remember anything since she had the severe pain on the stairs. Oct. 14th.—Patient's history from 26th is merely a record of her progress towards complete recovery. The pot. iod. was continued as long as there were any symptoms of disturbance. The face became straight, and the left arm and hand recovered their strength, though this was the last to be restored. Her urine was examined repeatedly, without finding a trace of albumen. The pain in her head was combated with repeated blisters, and was entirely relieved when she went out.

CASE II.—Mary Miller, at. 29, native of Ireland. Admitted to the Hospital Dec. 3, 1861 (service of Dr. Thomas). She was a well nourished vigorous appearing girl of moderately intemperate habits. Predisposed to phthisis. Menstruated at 14, always regular.

Monday, Nov. 24th, was taken sick with a severe pain in her head and limbs, and vomiting. Two or three days after her first attack she had a chill. Bowels regular until the 1st inst., since when she has not had a movement. Has had sleepless nights; has become very weak, and her appetite is lost; the pain in her head has been constant. Says that there was a boy sick much the same as herself in the house where she was living.

Symptoms on Admission.—Face and neck congested, eyes suffused and injected. Countenance dull, intellect slow. Skin hot and moist; she has a few petechial spots on the abdomen; abdomen somewhat distended, without tenderness; pulse 120 and quick; tongue moist, thickly coated with a white fur, large and tremulous; her head is very hot, and pressing on her forehead gives her pain. Nurse reports that since she has been in the ward she has had three spasms, in which she moved her head from side to side quickly, and frothed at the mouth. On physical examination of the thorax, crepitant râles were heard at the base of the lungs posteriorly as she was raised up, but they soon disappeared. Over the sternum there is a slight edema of the tissues, no edema of the feet. Ordered a blister, three by four inches, to the nape of the neck. Dec. 4th, 9 A.M.—Pulse 102, quick and small; tongue same; surface hot and dry; eruption very marked; intellect slow; breathes with an expiratory moan. The physical signs are as above noted. The blister drew well, and the pain in her head is relieved somewhat. 6 P.M.—On examination, converging strabismus is found to exist, more marked in the left eye; has vomited her dinner; has had another spasm. Ordered emplast vesicat, three by three inches, over both temples; B. Calomel, grs. x.; ice to the head. Dec. 5th, 10 A.M.—Pulse 120; tongue large and coated; surface very hot and dry; countenance anxious, and expressing much suffering; pupils normal; pain in her head intense; has slight photophobia, with diplopia. While noting her case she was seen in one of the convulsions alluded to before. She frothed at the mouth and gnashed her teeth, but did not move her head or limbs. Did not sleep last night; is much more stupid than on her admission. 4 P.M.—Pulse 120, soft and compressible; inclines to sleep; does not answer questions as readily as heretofore. Dr. Thomas ordered eight leeches over the occiput; ice continued. B. Pot. iod. 3*iv.*; aq. cinnamom., aquæ puræ, $\frac{1}{2}$ j.; M. ft. mist. D. $\frac{1}{2}$ j. q. 4 h. (grs. v.) Dec. 6th, 10 A.M.—Pulse 108; general condition the same; has not slept any, but lies in a semi-comatose state, rousing up on being suddenly called. Since last night her urine, which was treated on her admission without finding anything abnormal, has been re-examined with heat and nitric acid, and found to contain albumen: Sp. gr. 1015. Dec. 7th, 9 A.M.—Pulse 106; pupils normal; photophobia present; capillary congestion around the face and neck very marked; intellect very slow; bowels have not been open since the operation of purge. 7 P.M.—Bowels continuing confined, she was ordered calomel, grs. x., which was immediately rejected, and she was then given grs. viii., which was re-

tained. Dec. 8th, 10 A.M.—Pulse 120; tongue clean; surface natural; has no pain in the head; bowels were not moved by the calomel; to have a saline mixture. 7 P.M.—Pulse 104; has slight pain in her head; bowels freely opened; has slept some during the night; pain in her head entirely gone; answers questions more readily than before; photophobia less; strabismus and diplopia are much improved. 7 P.M.—Sleeping. Dec. 10th, 9 A.M.—Pulse 96; tongue large and moist; whenever she turns in bed she has some pain in her head; slight strabismus still present; appetite begins to return; treatment continued. Dec. 11th to Dec. 16th.—Continued to improve; pulse ran at 72 for three or four days. The strabismus entirely disappeared. 7 P.M.—Strabismus again present; pulse 96; tongue natural; pain in her head, with slight photophobia and diplopia. Ordered cold to the head, and blisters to the temples, pot iod. cont. Dec. 17th.—Same symptoms as yesterday, only more marked; blisters to the back of her neck repeated; bowels confined since the 13th. Ordered calomel, grs. x. Dec. 21st.—From this date the patient continued to improve without further drawback until she went out. The strabismus existed long after she got up, and for some time there was considerable unsteadiness of gait. But she gradually recovered from these, and Jan. 22, 1862, patient was discharged well.

Remarks.—The greatest interest was felt in this case throughout, and especially when it first came under notice, from the difficulty of making a differential diagnosis between meningitis and typhus fevers. The fact that the patient came from a neighborhood which had sent many cases to the fever wards, and that there had been another patient sick in the same house, and finally, the presence of the petechial eruption, all led to the primary opinion that it was typhus fever, but the subsequent progress of the case cleared up all doubts, and the result of the treatment exceeded the most sanguine expectations that were entertained in regard to it.

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, April 28, 1862.

DR T. C. FINNELL, PRESIDENT, IN THE CHAIR.

(Continued from page 322)

OVARIAN TUMORS.

DR. PARKER exhibited a multilocular ovarian cyst, which had been removed by ovariotomy from a lady, thirty-one years of age, the mother of three children, the youngest born last June. In January, 1861, on account of enlargement of the abdomen she supposed herself pregnant, but her physician having some doubts about it a consultation was called some time in June, when ovarian dropsey was discovered. She was then tapped, and about twenty pounds ofropy fluid evacuated. The canula remaining in at that time for three or four days a considerable degree of local peritonitis was excited. The fluid, however, reaccumulating, the operation for tapping was performed several times at intervals of four or five months. When first seen by Dr. Parker, about the 1st of April, she was relieved by tapping of about twenty pounds of fluid, three or four different cysts being emptied. Being anxious for permanent relief in the shape of an operation, Dr. Peaslee was called in consultation, and it was decided to remove the tumor. Menstruation had always been regular, occurring about the first of every month, and accordingly the time for the operation was fixed for the middle of the month (April). On the day of the operation it was found that for twenty-six hours previous she had experienced uneasy sensations, which were referred by her to menstruation, but as no discharge had appeared it was thought best to proceed. She was placed under the influence of ether, and an incision

was made about four inches in length half way between the umbilicus and symphysis pubis down to the peritoneum. A quantity of serum then escaped from the cavity of the peritoneum itself. The adhesions in the neighborhood were very slight, and the trocar was introduced into the sac, and about two gallons of fluid were drawn off. In addition to slight adhesions at different parts of the tumor there was one about the size of a two-shilling piece existing between the sac and the under surface of the liver, and also a pretty firm band in the immediate situation of the canula, which had been left in after the first operation. When the surface of the sac was being separated, considerable hemorrhage took place, and haste was accordingly made to find the pedicle in order to terminate the operation as soon as possible, and secure any vessels which might then be brought into view. The incision was then enlarged to ten inches, and the pedicle, about eight or nine inches in length, was found. The clamp was applied, but broke, a second one was then used, and the whole diseased mass, weighing eighteen and a half pounds, was removed. It was then found that the principal amount of hemorrhage came from that portion of the inferior surface of the liver from which the adhesion was torn off. Pressure was first made with a sponge to control the oozing, but that procedure failing Squibb's liquid persulphate of iron was applied with the desired effect. The wound was closed with four wire sutures, and the clamp brought outside.

The operation was performed about two P.M., and at four the pulse was 120. At nine P.M., however, the patient having slept a couple of hours in the meantime, the pulse was reduced to 110. She then for the first time began to complain of uneasiness in the epigastric region. At one A.M. she began to sink, at six her pulse was 130, and at two P.M., twenty four hours after the operation, she sank and died.

The autopsy was made five hours after by Dr. Sands. The wound was found closed throughout its whole extent by plastic lymph. There were evidences of extensive adhesive inflammation over both the parietal and visceral surface of the peritoneum. There were no signs of hemorrhage from the surface of the liver. A small amount of serum was found in the pelvic cavity, and the vascularity of the peritoneal covering of the uterus was quite marked as compared with the same tissue in the immediate neighborhood. The under portion of the liver near its right border was occupied by several soft nodules varying in size from a small shot to a cherry. A number of cysts were on the posterior surface of the bladder and uterus. The uterus was enlarged, but on being cut open showed no signs of menstruation having taken place. No grapsian vesicle was found ruptured.

DR. KRACKOWIZER expressed his surprise that so much should be said by authorities on the danger of prolapsus of the intestines during the operation of ovariotomy, as the abdominal walls from their relaxed condition as the result of over-distension were incapable of exercising any contraction. A wound of the abdomen in health would of course be complicated with protrusion.

DR. PEASLEE referred to a case which he had, where in operating the patient was seized with vomiting. The administration of the ether was in consequence suspended, and the bowels came out, giving a good deal of trouble before they could be returned.

DR. PARKER remarked that he did not like the clamp, and indeed was inclined to think that in some cases, for instance where a good deal of tympanitis existed, it would be productive of a good deal of harm.

DR. MARION SIMS lastly exhibited three specimens of ovarian tumors, and gave their histories as follow:—

The first case was that of an unmarried female, about twenty-nine years of age, who enjoyed ordinary good health until five years ago, when she first noticed an enlargement of the abdomen in the neighborhood of the right iliac region. This went on increasing in size until last Fall, when she consulted Dr. Emmet. He gave it as his

opinion that it was a unilocular ovarian cyst. She returned to the country, where she resided, and came to the city again in January. She had never been tapped, was quite emaciated, and measured sixty-two inches round the abdomen. I explained to her the dangers of the operation, and the chances for success. The operation was performed last February, and when the tumor was removed it was found to be a single cyst. I procured a clamp for this case, but it was not suitable to my purpose, and I simply used a few strands of soft wire, with which I perforated the pedicle, twisting the ends on either side. She recovered with great difficulty from the anaesthetic, and vomited nearly all night. Her pulse was 108. Dr. Emmet gave her large quantities of Black Drop, by enemata. She vomited more or less for two or three days, at the end of which time she was in a very prostrated condition. I differ with Dr. Emmet in my opinion regarding the use of such large doses of opium. I suggested the propriety of smaller doses systematically administered, when from that time she commenced to improve, eventually getting well. The pedicle was some twelve or thirteen inches in extent, and was connected with the broad ligament instead of the ovary—thus, when the pedicle was drawn outside, the ovary also made its appearance. The ovary was returned and the wound closed. But during the second day the ovary was pushed out during the act of vomiting, and there it remained for three weeks, until the parts healed, when it seemed to have shrunk away and become agglutinated in the wound.

The other case was a lady about thirty years old, the mother of five children, the youngest about six years old. Soon after the birth of the last child, some enlargement of the abdomen took place, which gradually increased. About a year after, she consulted me, and, at that time, I did not think, with reference to ovarian tumors, what I do now, and accordingly gave her a very unfavorable prognosis, and advised her to prepare for death, like a good Christian woman. I saw her no more until the month of March last, when Dr. Van Buren sent her to me. Within the last two years she had been tapped four or five times. On examining the tumor, I found it constituted, in its upper part, of a large cyst, and, in its lower part, of a firm, semi-elastic kind of mass. The operation was performed about six weeks ago, in the way already described. The large sac was opened, and the tumor pulled out as far as possible, when we came to the solid mass. The abdominal opening was then enlarged to five inches, and the whole mass was removed. The pedicle was fastened, as in the former instance, with a wire. After removal, the tumor was found to be made up of a cyst, on the one hand, and honeycomb texture filled with albuminoid secretion, on the other. The recovery was complete and rapid, the pulse at no time being over 90 per minute.

The other case was that of a lady 38 years of age, who came to the city last October, and consulted Dr. Emmet. He expressed the opinion that it was a multilocular ovarian cyst, and advised her not to have it punctured, looking on such an operation as predisposing to adhesion. However, she fell into the hands of another physician, who advised her differently, and tapped her. The procedure was followed with great prostration and symptoms of peritonitis, which lasted for several days. The abdomen then filled up very rapidly, and in the course of five or six weeks the operation was performed again, and seven gallons of fluid drawn off; four weeks after she was tapped again. No unpleasant symptoms whatever followed the two last operations. After that I saw her and told her that her case was a very unfavorable one for operation—presuming from the great amount of constitutional disturbance which followed the first puncture that extensive peritonitis had taken place, followed by adhesion. I, however, proposed to her an exploratory operation. She consented to such a measure, but refused to take any anaesthetic. After the incision was made in the abdominal wall, the fingers introduced discovered firm adhesions on every side. In the

efforts to break up some of the adhesions the large cyst was ruptured, and about twelve or thirteen pounds of fluid escaped. The operation of course was not proceeded with, and the wound was closed. She went on really well for a week after the operation, when the second case already related was operated upon. Dr. Mott and Dr. Stevens were present, and the former gentleman gave me the history of a case in which he some time ago tapped a patient for ovarian dropsy, but the wound remained pervious, an almost constant discharge being kept up from the sac. That case, he said, eventually terminated favorably. The idea suggested itself to me that it would be well to imitate nature in the case of the lady who had been tapped, and with the consent of both Drs. Mott and Stevens, I took a probe and gently opened the wound. About half a gallon of fluid escaped. But in the course of thirty minutes the patient was in a state of collapse, and she vomited for twenty-four consecutive hours. She was alarmed by the constant escape of the fluid, and begged me to stop it. This I did by closing up the wound with sutures, and, to my surprise, as soon as the exudation was stopped she began to rally, went to sleep, and for two days looked as if she were going to get well, but she died at the end of a fortnight.

In conclusion, Dr. Sims remarked, that the great improvement in the operation of ovariotomy as now performed, is in bringing the pedicle outside of the abdomen, and the substitution of the metallic for the silk ligatures.

No other specimens appearing, the meeting was on motion adjourned.

American Medical Times.

SATURDAY, JUNE 14, 1862.

A REMEDY FOR AN EVIL.

THE many-sided phases of the War of the American Rebellion will furnish exhaustless themes for future aspiring historians. Its rise, progress, and downfall; its causes and consequences; its political and social bearings; its diplomacy; its romance and reality; its influences upon the progress of military, naval, and medical sciences—these are a few of its features which will be deemed worthy of record and preservation in the archives of American history. But who is to do the world the service of recording, with impartial hand, its bad surgery; the limbs wantonly sacrificed; the lives lost that would have been saved by timely operations; the unseemly incisions; the careless dressings; the neglect of medical treatment? These are not the most unimportant features of this war, but unfortunately they shun observation and record, and too frequently, alas! quietly seek the oblivion of the grave.

It were doubtless asking too much, that our surgical records of this war should be unblemished by fault or default. The principles and practice of military surgery are not all so firmly established that they can be invariably reduced to fixed rules. Too great license is still given to the army surgeon in the practice of his profession, even by our best text-books. The uncertainty arises from that diversity of opinion which grows out of statistical inquiry—too frequently most deceptive in its conclusions. But though we may not insist that the army surgeon shall have the highest degree of skill, we may require that he shall have an average knowledge of his profession, and exhibit in his practice a reasonable share of good sense and

sound judgment. This degree of knowledge should certainly be expected of one who has the unlimited power for evil of an army surgeon. We plainly do not demand too much, when we require that he should exhibit more professional knowledge and skill than a layman; and yet even this modicum of qualification is not always found, as the visitors to some military hospitals attest. There have been noticed stumps of amputated limbs in which the bone protruded several inches beyond the unsloshed flesh; others in which the flap was made by cutting from without inwards and from above downwards, instead of the reverse direction. It is true that these are very exceptional cases, but they prove, nevertheless, from what a low level the gradation of surgical qualification commences. Nor can they fail to suggest that if such utter ignorance of the mere art of surgery exists in the army, even to the most limited extent, what a deficiency in a knowledge of its science may be found. And if we trace these delinquencies to their legitimate results, who will not turn with horror from the page of history that bears their record?

We must not be understood as taking an unfavorable view of the Medical Staff of the Army at large; we believe that the surgeons in general are competent and fully adequate to their duties, and it is worthy of record that the best surgical talent of the country is represented in the corps. Nor are we deprecating a state of things which could easily have been prevented. The draft upon the medical profession of the country to supply the regiments with surgeons was excessive, and necessarily that floating class of practitioners who live by their "wits" rather than their knowledge, are ready to volunteer, and many found situations. We allude to the subject now because the sad results of incompetent, blundering, and inefficient surgery, are beginning to be apparent, and cannot longer escape notice.

Is there no remedy for bad surgery? Shall a class of surgeons in the army blunder through these rich fields which the ripe experience of the past enables us to improve, as ignorant of their duties as if in the armies of the middle ages? We think not. There is a simple remedy which the proper authorities might, and, we believe, in the interests of medical science and humanity, ought to apply.

Many of the rules of practice in military surgery are now so well established that they do not admit of question. The Sanitary Commission has done much to place these rules before the medical staff in a readable form, but they admit of much greater condensation. Let the Surgeon-General, or a Commission of Surgeons appointed by him, reduce these rules to aphorisms, provide each surgeon with a copy, and enjoin him to follow them strictly, where the rule admits of no doubt, and qualifiedly where the discretion of the surgeon *must* be allowed. It may be alleged that such a proceeding would be arbitrary, but it is simply a matter of saving life, and all individual feeling should yield. We believe, however, that the surgeons of the army would receive such explicit rules of practice with great favor, and follow them in good faith.

A LOOP OF RED-TAPE SEVERED.

WE commented in our last issue upon the evils of Red-tape, and alluded, in passing, to the difficulties of obtaining the discharge and transportation home of the invalided soldiers. Simple as such a process might be made in the

hands of any business corporation, it involves an amount of detail, travel, and annoyance, that would exhaust a person of ordinary physical energies. We heartily rejoice that this complicated business is to be simplified by an Act of Congress. No one can fail to appreciate the importance of the change who has visited those invalids, scattered through all the hospitals, and listened to their tales of disappointments. An evening paper thus aptly notices the matter:—

"In the House, Mr. McPherson offered a resolution in regard to the organization of the Army Medical Department. The object of Mr. McPherson was to cut in two an annoying and harmful piece of red-tape, which had prevented the execution of a wholesome act of Congress. Congress ordered that maimed and wounded soldiers, not fit to re-enter the service, may be discharged, if they request it, outright, from the hospital where they were sent. Instead of that, for some reason of red-tape, it has been held necessary, in order to obtain a maimed and homesick fellow his discharge, to send an application and certificate to his colonel, who sends it to his brigade commander, who must forward it to the division commander, who, when he gets time, sends it to the chief of the army corps, who forwards it to headquarters, where it necessarily lies at the bottom of an increasing mountain of more pressing matters. Meantime, hundreds of soldiers are languishing in the hospitals, homesick, anxious to get home, where they could have kind words and familiar faces around them, and cannot go, because the Army Medical Department is tangled up in a monstrous mass of red tape, which could be kept clear by vigorous exertions while our army numbered eighteen thousand men, but is fatally snarled now that half a million are to be looked after."

In this connexion we cannot withhold a private communication from a surgeon of a distant city who has spent much time in the army. He will excuse the liberty we have taken with his interesting letter:—

"I coincide most fully in the views expressed in the editorial of the MEDICAL TIMES of Saturday last. A fearful responsibility rests somewhere in relation to the proper provision to meet the casualties and sickness of the Army of the Potomac. Many regiments were destitute of the simplest and most essential articles, and I was assured days must elapse before the articles could arrive after a requisition was made. The requisition was required to pass through *two* or *three* approvals, and finally be sent a distance varying from four to ten miles before it could be filled. I was credibly assured that the whole medical and hospital supplies of all kinds at that time there were on a *barge* not as large as most of those on the North River. And this was the amount of material for an army of one hundred thousand! Had not the Sanitary Commission come on with their enormous supplies, both for field service and fitting up transport vessels, humanity must have mourned at the fearful loss of life, for I have reason to believe, not *even a bed, sack, or blanket*, could have been spared for transport service, not to speak of the many other necessaries requisite. I do not pretend to fix the blame, nor to be critical or cavilling, but I did not meet with many who seemed fully alive to the fearful emergency before them. Look at the transport service, for which not one whit of provision was made, and by whom has it been performed? True, it has been in Government vessels, but they were fitted, equipped, and controlled by the Sanitary Commission. It is fortunate for the country that such accomplished, noble hands, were ready to assume it."

"I write with not the slightest view to publicity, but simply to assure you there is *very great truth* in your statements, and that a crying need exists for simplifying the long routinism—more than all to cause those of the Medical Staff who are doing administrative or staff duty, to know their responsibility does not end with signing this

or that paper, but their personal efforts must be added to give it efficiency."

THE WEEK.

The proper disposal of the sick and wounded soldiers of the armies of the seaboard has become, as we foresaw it must, a most important question. The hospitals at Yorktown, Fort Monroe, Washington, Philadelphia, and New York, are crowded, but the influx is on the increase. On Saturday last, the steamer C. Vanderbilt brought into this harbor six hundred and fifty wounded, a sufficient number to fill a hospital of reasonable dimensions. We are now in great danger of crowding the hospitals, already opened, to excess: it were much better to place patients in tents in the open fields. It is quite evident that the large cities of the seaboard are soon to be surrounded by hospitals, and that the sympathies of the citizens will be overtaxed by the constant and excessive draught made upon them. The proper method of meeting this exigency is to distribute the sick and wounded more widely than has yet been done. Instead of congregating them in large cities, they should be distributed in all our northern towns accessible to transports, care being taken to locate them as far as possible in the states from which they enlisted. We can mention fifty towns, and probably there are fifty more, where transports could discharge the sick directly at the door of the extemporized hospital; if each of these towns should receive three hundred patients, the total number provided with accommodations would be fifteen thousand. The advantages of this distribution of disabled soldiers would be very great. The sick would be in their native climate, and surrounded with associations tending to promote cheerfulness and health. The open country where such structures would be placed would be greatly preferable to city hospitals. The local community would take delight in bestowing their gifts personally upon the soldiers, and the supply of those delicacies for which the sick so frequently make inquiry, would be abundant. The medical attendance would be spontaneous, and untiring, and equal to any emergency. Let us then have small hospitals opened at every considerable town on the seaboard and on the large rivers, from the Chesapeake to St. John's.

We learn that Bellevue Hospital is to receive wounded and sick soldiers. This is a movement that should have been made before. At this season of the year its wards are but partially filled, and it can, without any great crowding, admit six hundred additional patients. The location of the hospital building on the East River renders it accessible to transports. The Hospital is at present in admirable condition, and we hope there will be no delay in opening its spacious and well appointed wards to the soldiers who require such accommodations.

The House of Representatives has passed a resolution directing our Generals to subsist their armies on the enemy. If this had been the early policy of the Government it would have saved much unnecessary suffering. At the White House the sick soldiers have recently suffered greatly from insufficient food, while the cattle of rebels were allowed to graze their pastures undisturbed. A volunteer surgeon of this State caused an ox to be slaughtered to relieve their destitution, and was severely reprimanded for

his (humanity?) disregard of the rights of traitors. We shall now have less sickness and death in our armies.

The Philadelphia College of Physicians is about to erect a Hall for its special purposes, being stimulated thereto by the bequest of \$30,000 by PROF. MUTTER. This sum was assigned to the College on condition that a building was erected within a given time. The structure will be forty-five by one hundred and seven feet, the material of brick, and it will contain rooms for a museum, library, and hall for meetings. The College of Physicians will thus provide for Philadelphia what the Academy of Medicine should provide for the profession of New York. The Academy is the leading local medical society in the United States—probably embraces most wealth, still it is content to occupy a single badly ventilated room, without one facility for a museum or library. The Academy owes it to its own reputation to secure a suitable building of its own in a central position; it would thus greatly enlarge its influence, and become the generous patron of the profession.

Reviews.

COMMENTARIES ON THE SURGERY OF THE WAR IN PORTUGAL, SPAIN, FRANCE, AND THE NETHERLANDS, from the battle of Rolica in 1808, to that of Waterloo in 1815; with Additions relating to those in the Crimea in 1854-1855, etc. Revised in October, 1855. By G. J. GUTHRIE, F.R.S. Sixth Edition. Philadelphia: J. B. Lippincott & Co. 1862. Pp. 614.

NOTES ON THE SURGERY OF THE WAR IN THE CRIMEA, with Remarks on the Treatment of Gunshot Wounds. By GEORGE H. B. MACLEOD, M.D., F.R.C.S., formerly Surgeon to the Civil Hospital at Smyrna, etc. Philadelphia: J. B. Lippincott & Co. 1862. Pp. 403.

A TREATISE ON GUNSHOT WOUNDS. By T. LONGMORE, Esq., Professor of Military Surgery at Fort Pitt, Chatham. Philadelphia: J. B. Lippincott & Co. 1862.

The three publications above mentioned, are timely issues from the press of the Messrs. Lippincott. The present war found us deficient in military surgical works, and so urgent was the demand, that the supply from abroad was never sufficient for the market. The reproduction of these standard works was, therefore, very important to the surgeons entering the volunteer army. Of the intrinsic value of the two first works it is not necessary to speak; they belong to the classics of surgical literature, and will long remain the best guides to the military surgeon. The last work is the reprint of an able article furnished to the *New System of Surgery*, now issuing from the London press, and embodies the present state of military surgical science and art. It is eminently worthy of reproduction in its present form.

ANATOMY, DESCRIPTIVE AND SURGICAL. By HENRY GRAY, F.R.S. The Drawings by H. V. CARTER, M.D. The Dissections jointly by the Author and Dr. Carter. Second American, from the revised and enlarged London Edition, with Three Hundred and Ninety-five Engravings on Wood. Philadelphia: Blanchard & Lea. 1862. Pp. 876.

This large and compendious work on anatomy has become the text-book of all our schools. As a treatise on general as well as relative anatomy, we cannot sufficiently commend it to the profession. The present edition contains the last revisions of the author, and has been rendered still more convenient for reference by the American editor.

Correspondence.

CONNECTICUT MEDICAL SOCIETY.

The seventieth annual meeting of this society was held in the city of Bridgeport on the 28th and 29th May, with a full attendance of Fellows from the county societies. There were also present, as delegates, Drs. H. D. Bulkley and J. G. Adams from the New York State Medical Society, and Dr. Usher Parsons from the Medical Society of Rhode Island. The first day was occupied in the transaction of routine business, and in the election of officers for the year ensuing. Dr. Josiah G. Beckwith, of Litchfield, was re-elected President; Dr. E. K. Hunt, of Hartford, Vice-President; Dr. Geo. O. Sumner, of Hartford, Treasurer; and Dr. Leonard J. Sanford, of New Haven, Secretary. Delegates were appointed to attend the annual meetings of the Massachusetts, Rhode Island, New Jersey, and New York State Medical Societies. Drs. Knight of New Haven, Hunt of Hartford, and Beckwith of Litchfield, constitute the delegates to the latter (New York) society. It was voted that the next annual meeting be held in Tolland county, the town to be hereafter designated by the committee. Drs. Jared Linsky and John G. Adams, of New York, were elected honorary members of the society.

In the evening the society was most hospitably entertained at the residence of Dr. Robert Hubbard of State street.

On the 29th the society convened at 10 A.M.; a larger attendance than on the day previous, amounting in all to seventy-five. Seven hundred and fifty copies of the Transactions were ordered to be printed, including the following papers:—On Diphtheria, by G. B. Hawley, M.D.; On Two Anomalous Cases of Disease, by D. Crary, M.D.; Hypodermic Medication, by B. H. Catlin, M.D.; On the Sympathetic Nerve, by M. G. Hall, M.D.; Case of Cerebro-Spinal Disease, by Ralph Deming, M.D.; Sketches of the Early Physicians of Norwich, by A. Woodward, M.D.; On Ligature of External Iliac Artery, by J. W. Lawton, M.D.; Plastic Constituents of the Blood, by L. J. Sanford, M.D. Dr. H. N. Bennett, of Bridgeport, exhibited a case of resection of the shoulder joint for an enchondromatous tumor. Patient has now the free use of his hand and arm, and is in good health. Dr. B expressed the opinion that the operation was unique; he had never heard of resection of the joint for this disease. Dr. Catlin read the report of the committee on Registration; he deplored the ill-success which had attended the labors of the committee, more particularly as regards registration in the smaller towns and villages throughout the state. The President then delivered his annual address. Dr. White, of New Haven, read a dissertation on the Spontaneous Generation of the Infusoria. Dr. Knight made some remarks in relation to the New Haven Hospital; spoke of its prosperous condition, and of its capacity to accommodate three hundred patients. Dr. Jackson, of Hartford, was chosen Dissertator for the next year; and Dr. Robert Hubbard, of Bridgeport, alternate. In the afternoon the society dined together at the "Sterling House;" Dr. Knight presiding in the absence of Dr. Wm. B. Nash. He welcomed the members of the society, delegates from other societies, and invited guests. He remarked that but one member, as old as himself, was present, and that but eight or ten remain of those who were his contemporaries.

Addresses were afterwards made by Dr. E. K. Hunt (Vice-President), Drs. Bulkley, Rockwell, Talcott, Knight of Lakeville, Deming, Hubbard, and Childs. After which the society adjourned.

A.

SHELTER CLOAK-TENT.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—Allow me to call the attention of your numerous readers in the medical corps of our army to a new and comprehensive Cloak-Tent, recently introduced to the

notice of the Belgian government, and which, although as yet but an experiment, deserves the consideration of a trial, as possibly assisting to relieve transportation trains, while at the same time furnishing the soldier with a shelter on the march as well as during the bivouac.

Capt. Sheureux, the inventor, proposes to furnish each soldier with a piece of india-rubber cloth, in the form of a rectangle, seven feet by three and a half, which on the long sides shall be pierced with eyelet-holes, having rings inserted in them. A small cord reeving through these enables the wearer, when marching in the rain, to gather one of the ends together in the form of a plaited cone; this passed over the head and hanging from the neck, entirely covers the man and everything he carries. At night, when desirous of converting it into a tent, he fastens one of the narrow sides to the earth, and elevates on a couple of sticks the opposite end—thus covering a space of about six feet by three and a half. His knapsack, serving for a pillow, is placed at the apex of the triangle thus formed, and his feet towards the open end and the camp fire. Four men by uniting their cloaks can in this way form a sort of Sibley tent. If the number of cloaks be still further increased, so as to impart a polygonal shape to the structure, there will be room enough for a fire in the centre, while the square ends of the cloth will always insure a large opening at the top for the escape of smoke and the purposes of ventilation. But this is not the general purpose sought for in their construction. They are more especially designed for one, two, or four men bivouacking by squads, and not for a larger number making a permanent habitation of it. The merits claimed for it by its author are, portability, shelter, less danger of fire, facility of construction and removal, and, lastly, by having their open ends towards the camp-fires, they conceal these latter from the enemy's observation.

Yours, etc., J. O.

ROSLYN, May 31, 1862.

MILITARY HOSPITALS.

[NEWBERRY, N. C., May 26, 1862.]

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—In the years 1838-39 I had the honor, by authority of the Board of Managers of the "Preston Retreat" of Philadelphia, and by a special committee of the College of Physicians (Meigs, Ruan, and Huston), to visit the several hospitals throughout Europe in order to obtain the best plan for the erection and organization of this Lying-in Hospital in Philadelphia. A large legacy had been left by a benevolent physician for this purpose, and it was thought that something might be learned from the examination of similar institutions in Europe. In this tour, which embraced England, Ireland, Scotland, Wales, France, Belgium, Prussia, Saxony, Austria, Switzerland, and Italy, I necessarily came in contact with various hospitals designed for other purposes than obstetrics. Among the institutions which I visited, none interested me more than the military hospitals. These were to me, of course, entirely new, our country not at that time having established many of the kind. This has been the case up to the present war. Our country now finds itself in a position demanding the immediate erection of a large number of institutions for the accommodation of sick and wounded soldiers. A war carried on by one million of men in the field, even for one year only, will incur the necessity of the establishment of economical accommodations for its soldiers after the war. The truth is, the battle of Bull Run opened the eyes of the Government to the pressing necessity of fitting up immediately proper buildings for the accommodation of the sick and wounded. The consequence was, and is, that large buildings in Alexandria, Georgetown, Washington, Philadelphia, New York, and elsewhere, have been fitted up for the temporary accommodation of the wounded. I say temporary accommodation, for it is not probable they will remain as permanent fixtures after the war is over. There will be many wounded and disabled men whom the Government must take care of during their lives. There will be many sick of diseases con-

tracted in camp who will equally need care and medical attention from the Government; and there will, in future, be a much larger standing army than formerly, which will annually supply large numbers of sick and wounded soldiers to these hospitals. The Government will be generous to these men. One or more *hotels des invalides* will be erected for them. A great deal of money has already been expended under the pressure of an urgent necessity for the present accommodation of these men, and a great deal more will be spent in the same way. The fact is clear to almost any ordinary observer that this mode of proceeding cannot continue long. Some permanent, safe, and economical structures must be erected, with all the necessary conveniences and hospital accommodations; they must be erected on high and airy places, outside of the thronged thoroughfares of large cities, away from the influence of malaria, and under the influence of proper military and medical discipline. The land must be obtained cheaply, the buildings must be erected economically, on plans which promise "the greatest good to the greatest number," and the organization of the institutions so arranged as to cost the Government as little as possible. Now, I do not know what money has been spent in this direction already, but I do not doubt that enough has been spent to have erected one or two fine, large institutions of this kind. In examining the hospitals of Europe, nothing attracted my attention more than the strong disposition exhibited by the several governments, through their agents, to obtain the best possible ventilation for the hospitals. Next to this, an equal temperature was sought for, high and dry ground was selected to secure fresh air, as well as for purposes of cleanliness. In France, Germany, and Italy I found stoves or *pôles*, the latter a kind of brick-work, in general use in the hospitals. In some cases, ordinary fire-places were used. The large wards of the hospitals in Rome and Naples, in addition to having no means of heating them, had cold brick or tile floors with a central gutter running through them, through which streams of water were allowed to pass to clean out the wards. I confess I felt cold and shivery in walking through the large wards of the Spedale Maggiore of Rome, during the month of December. A new hospital the same season being built in London was heated by pipes containing heated steam, and the lying-in hospitals of the same city, the best of them, were fitted up with carpets and the ordinary furniture of a well arranged house, including a good coal fire in the grate. The ventilation in some of the hospitals, especially the older ones, was simply the ventilation of windows opened and shut; in others a single pane would open, in other cases there would be perforations in the walls with valves at the ends and sides of the wards. These were accompanied with openings in the doors or in the walls near the floor, designed to keep up continuous currents of fresh air through the wards. The further south I went the more gregarious I found the people, the larger the wards in the hospitals, and the stronger the disposition to a *table-d'hôte* life; while in England and the north of Germany the disposition appeared to be to divide up the spaces, make the rooms small with fewer inhabitants, in more numerous apartments. The expense of keeping the atmosphere at a proper temperature during the cold weather would dictate this policy as a matter of economy. English exclusiveness, in my estimation, arises in a great measure from the surly and disagreeable character of the English climate. But, to return to the matter of our military hospitals, I would suggest to the Government the propriety of preparing at once to meet this necessity of the condition of our country. Let a competent person or persons be appointed to visit Europe if necessary, organize proper plans for the erection and conducting these military hospitals, and in general have the supervision of the matter. It will require more than one year to erect the buildings alone, and they should not be begun until the best possible plans, architectural and other, adapting them to the different climates where they shall be erected, have been fully determined upon. By taking a

step thus early in this matter, the Government will save many expenses and losses, which would otherwise occur, under the pressure of necessities. I need scarcely refer you to the enormous losses of the Government occurring from the sudden calling out of half a million of men, without previous concert, consideration, or experience. There certainly have been great losses by the undoubted corruptions of the contractors of the Government, as there will be in almost any distribution of governmental patronage, but the inexperience of its agents in the duties which they were called upon suddenly to perform, is and was the real cause of many of the great losses suffered. Besides this, I would urge a movement at the present time in this matter, in order that we may have time to perfect the organization of these institutions. Our patriotic pride should induce us to make them as perfect as possible, better than those in Europe. Some of our institutions have for years been models to Europe, and there is no reason why we should not excel in this direction.

Yours, etc. JAMES BRYAN,
Brigade Surgeon, Burnside's Expedition.

FOREIGN CORRESPONDENCE.

By PROF. CHARLES A. LEE.

LONDON, May 14, 1862.

As I promised to send you some "medical jottings by the way," I embrace the first opportunity to post up to the present time. Leaving New York on the screw steamer Kangaroo, we had a very rough and uncomfortable passage of fourteen days before reaching Liverpool. As usual, I suffered from sea-sickness all the way. Were I to name all the remedies and specifics for this malady which were recommended me on board, from *salt water* to *chloroform*, I should have no room for anything else in my letter. Suffice to say, I tried none of them but *champagne*, a basket of which was sent me by a friend, on board the vessel; this, cooled on ice, and taken *ad libitum*, came nearer my idea of a *specific* than anything I could imagine; *taken as a medicine*, for this, and other kinds of nausea and vomiting, I give my voice decidedly in its favor. Some of my companions, miserable wretches, took *chloroform*, on some anonymous recommendation, and suffered more from the remedy, as often happens, than from the disease. *Effervescent mixtures*, like soda and seidlitz powders, and "Farrant's effervescent mixture," of like composition, answered a good purpose in some cases. Most of the sufferers consoled themselves with the idea, that the after benefits would more than compensate for the present suffering; an opinion not exactly consonant with my own experience or observations. I am not about to trouble your readers with an essay on sea-sickness; for although I know much about it experimentally, I have little knowledge of its true pathology or proximate causes. No one is better acquainted with its symptoms and phenomena than myself, beyond this I make no pretensions. I will, however, venture to offer a reward of one hundred pounds sterling, to any one who will discover a certain and infallible specific, to be paid by penny subscriptions from all who experience its benefits.

The next subject which pressed itself on my attention, especially as a sanitarian, was the miserably deficient ventilation of the ship. As I occupied a cabin nine feet square, with only four other passengers, taken promiscuously, and that situated just over or near the machinery, where the smell of oil, tar, grease, coal oil, bilge-water, etc., was overpowering, and adjacent also to the cooking department, where, if I could not eat, I had all the benefit of the various savory smells given off by the various dishes, I may say that I labored under difficulties in attaining that degree of comfort which is desirable on a pleasure trip, although it might be endured with patience were there no remedy. We have studied hygiene and sanitary regulations on land long enough to transfer some of our researches, as it seems to me, to our vessels; and especially those engaged chiefly in transporting passengers. A more perfect system of venti-

lation on board ship is the great desideratum; and I am very glad to find it is occupying more and more the attention of the medical officers of the British as well as American navy. Although the surgeons of the Royal Navy have, year after year, represented in their Reports to the Admiralty, through the Director General, the influences injurious to health which prevail on board ship, and the best means of remedying them, and though some improvements in the ventilation of the public vessels of Great Britain have recently been introduced, yet they have not become general, and many of their regular sailing sailing packets and steamers are deprived of their benefits. The Reports, to which I have referred, are based on observations and experiences in ships of various classes and under every variety of circumstances and climate; and the same may be said of the reports of our own naval medical officers to our Naval Bureau. What is wanted is, the adoption of such measures as will obviate and correct the evils so fully pointed out. There is still ample room for improvement, both as regards cleanliness and ventilation, in the forecastle and steerage of our passenger vessels, notwithstanding all that has been done to better the condition of emigrants on board ship; affording them more space, by legal enactments; and also more healthy food, and better cooked, than when this class of passengers supplied themselves with provisions, and quarrelled over the coppers, in cooking it. There certainly ought to be some means of enforcing personal cleanliness among these unwashed foreigners; for to bodily filth may doubtless be attributed much of the sickness prevalent in the steerage. I trust some of our skilled sanitarians, such as Dr. Griscom, Van Buren, or Joseph M. Smith, may turn their attention more particularly to this subject of *naval hygiene*, and prepare a work, so much needed, for the benefit of those who "go down to the sea in ships."

In passing through the great manufacturing districts of England, especially in the iron districts of Lancashire, as Wolverhampton and Birmingham, I observed much of the vegetation killed, especially the trees and hawthorn hedges, which is not much to be wondered at, considering the vast amount of noxious gases given off in the various manufacturing processes. On inquiry I find that the evil has become so great, and the injury to animal and vegetable life so extensive, that Parliament, on motion of the Earl of Derby, has just appointed a Committee to inquire into and report on the subject. The vapors which have proved so destructive to vegetation, are chiefly given off in the manufacture of soda from sea water and common salt; some establishments employing 1000 hands, and turning out 100 tons or more of soda annually. Some of the chimneys to these manufactories are nearly 500 feet high, for the purpose of carrying off and causing to be dispelled in the air without injury, the muriatic acid and other vapors generated in the process of manufacture. But this has proved an inadequate remedy, and heavy damages have repeatedly been recovered by the large landed proprietors in their neighborhood, from the owners, for injury done to their crops, hedges, and trees, etc.; so that, in many cases, the manufactories have been destroyed or abandoned. The process of the manufacture of soda, in England, is carried on by the decomposition of common salt by sulphuric acid; and in most of the manufactories I find that the manufacture of sulphuric acid also is carried on in the same building, by condensing the sulphurous vapors given off, and, in three cases, no injury is sustained by the neighborhood, while the profits are much increased. A patent was granted several years ago, to prevent injury from such acid vapors by passing them through water, which has a strong affinity for them, thus condensing and utilizing them. This is said to have proved very valuable to the patentee, though it cannot have been generally introduced.

The injury to animal life is hardly less obvious throughout these districts than to vegetation. This is shown by the high mortality rate, amounting in some places to over 20 instead of 8 in 1000, the average mortality throughout England.

Since reaching London, I have visited some of the hospitals, and become acquainted with several medical men of distinction. Several whom I knew when here in 1849, are now gone; as Bransby Cooper, Dr. Pereira, Sir John Forbes, R. B. Todd, Dr. Quckett, Marshall Hall, etc. Their places, however, are filled by men of equal ardor and devotion to science, if not of equal merit. The improvements and advance in medical and surgical science within the last ten years are very obvious; and for many of these improvements, the world is indebted to London practitioners. Dr. Copland, who may certainly be ranked among the first of living practitioners and writers, is still actively devoted to the practical duties of his profession, notwithstanding the immense amount of physical and intellectual labor he has accomplished. Sir B. Brodie has recently retired from practice, owing to the failure of his eyesight, although he has reached that age when men naturally seek for quiet and repose. No one, in modern times, has attained a more exalted professional reputation than Sir Benjamin; and it will prove as durable as it is eminent, for it is founded on researches which have contributed to enlarge the boundaries of science; while he has ever proved an example, and exhibited a character calculated to elevate the medical and surgical profession in the respect and esteem of society and the world. He, undoubtedly, has the great consolation in his declining days, to feel that he has acted his part well in life, and discharged his professional duties conscientiously. He has retired to a beautiful situation, at (Broome Park) Betchworth, Surrey.

I shall endeavor to write you weekly, though my time is much occupied. In my next, I will confine myself to subjects more strictly professional.

Medical News.

LIST OF THE NAMES OF SURGEONS AND ASSISTANT SURGEONS APPOINTED TO THE VOLUNTEER REGIMENTS OF THE STATE OF NEW YORK, SINCE MARCH 8, 1862, AND THE CHANGES WHICH HAVE OCCURRED IN THE REGIMENTS IN THE FIELD FROM THE SAME DATE.

March 8, 1862.—Charles S. Wood, M.D., Assist. Surg. 66th Reg., vice James D. Hewett resigned, March 13.—J. F. Blauvelt, M.D., Assist. Surg. 5th (Jackson) Artillery, organizing in New York City, March 21.—F. M. McLellan, M.D., Assist. Surg. Marine Artillery, promoted to Surgeon; Amos Geer Avery, M.D., Assist. Surg. Marine Artillery, vice F. M. McLellan promoted; John Z. Krauter, M.D., Assist. Surg. 103d (Eggleston) Reg., organized in New York City, March 24.—James W. Caey, M.D., Assist. Surg. 105th Reg., Rochester and Le Roy organizations, March 25.—William C. Lewis, M.D., Surgeon 2d Reg., promoted from Assist. Surg., vice Alfred Powell on parole; Joseph W. Robinson, M.D., Assist. Surg. 2d Reg., vice Wm. C. Lewis promoted to Surgeon, March 28.—William H. Leonard, M.D., Assist. Surg. 51st Reg., vice John L. Dodge, March 29.—Fowler Prentiss, M.D., Surgeon 73d Reg., promoted from Assist. Surg. 30th Reg., vice H. P. Bostwick resigned; James C. O'Neill, M.D., Assist. Surg. 25th Reg., vice Daniel H. Murphy resigned, April 2.—Charles L. Hubbard, M.D., Surgeon 12th Reg., vice Azariah B. Shipman promoted to Brigade Surgeon; E. M. Duering, M.D., Assist. Surg. 30th Reg., vice Fowler Prentiss promoted to Surgeon 73d Reg. April 10.—Asa B. now, M.D., Surgeon 1st Engineer Reg. (Col. Serrall), vice A. P. Dairymple resigned, April 11.—Ernest Cotelle, M.D., Assist. Surg. "Enfans Perdus" Reg., organized in New York, April 18.—Andrew F. Sheldon, M.D., Assist. Surg. 15th Reg., May 12.—John L. Dodge, M.D., Surgeon 51st Reg., vice Ephraim H. Buck resigned, May 13.—John P. P. White, M.D., Surgeon 10th Reg., promoted from Assist. Surg. 9th Reg., vice John W. Hunt promoted; Andrew H. Smith, M.D., Surgeon 94th Reg., promoted from Assist. Surg. 43d Reg., vice Chas. Goodale resigned; Thomas Lawyer, M.D., Assist. Surg. 43d Reg., vice Andrew H. Smith promoted to Surgeon 94th Reg.; Henry J. Phillips, M.D., Surgeon 102d Reg., vice Charles Goodrich resigned; Conrad Joschim, M.D., Assist. Surg. "Senges" Artillery, vice Chas. J. Kipp resigned; Franz Macke, M.D., Surgeon 98th Reg., promoted from Assist. Surg., vice F. Hessell resigned; Charles Stein, M.D., Assist. Surg. 35th Reg., vice Franz Macke promoted to Surgeon; James Chapman, M.D., Assist. Surg. 90th Reg., vice William W. Kinne resigned; William J. Burr, M.D., Assist. Surg. 59th Reg., vice Stephen P. Uhlein resigned, May 14.—Edward McDonnell, Assist. Surg. 1st Artillery, vice Alfred A. C. Williams dropped from the rolls, May 21.—F. Markoe Wright, M.D., Assist. Surg. Col. Dodge's Battalion of Mounted Rifles.

ERIE COUNTY MEDICAL SOCIETY.—The semi-annual meeting of the Erie County Medical Society will be held the second Tuesday in June, at the rooms of the Buffalo Medical Association, No. 7 South Division street.—*Buff. Med. and Surg. Jour.*

PUBLICATIONS RECEIVED.

The American Journal of Ophthalmology, Vol. I, No. 1, Julius Homberger, M.D., Editor and Proprietor. July, 1862. Baillière Brothers. Pp. 48.

A Practical Guide to the Study of the Diseases of the Eye; their Medical and Surgical Treatment. By Henry W. Williams, M.D., Fellow of the Mass. Med. Soc. Boston: Ticknor & Fields. 1862. Pp. 317.

Hints and Observations on Military Hygiene; with the best means of Treating the Medical and Surgical Diseases of the Army. By Lawrence Turnbull, M.D. (Reprinted from the Medical and Surgical Reporter.) Philadelphia: 1862. Pp. 62.

TO CORRESPONDENTS.

H. V. P. (Peru, Ind.)—We must refer you to the author of the article on *Sarracenia Purpurea*, Dr. F. W. Morris, 84 Argyle St., Nova Scotia, for a specimen of the article. We are not aware that it is for sale in New York.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 2d day of June to the 9th day of June, 1862.

Deaths.—Men, 78; women, 75; boys, 78; girls, 81—total, 315. Adults, 156; children, 159; males, 123; females, 159; colored, 5. Infants under two years of age, 99. Children reported of native parents, 22; foreign, 117.

Among the causes of death we notice:—Apoplexy, 4; infantile convulsions, 15; croup, 6; diphtheria, 10; scarlet fever, 15; typhus and typhoid fevers, 19; consumption, 62; small-pox, 5; dropsy of head, 9; infantile marasmus, 15; cholera infantum, 3; inflammation of brain, 10; of bowels, 9; of lungs, 15; bronchitis, 7; congestion of brain, 8; of lungs, 2; diarrhea, 6; whooping cough, 2; measles, 1. 151 deaths occurred from acute diseases, and 27 from violent causes. 198 were native, and 117 foreign; of whom 76 came from Ireland; 45 died in the City Charities; of whom 10 were in the Bellevue Hospital.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

June	Barometer.		Temperature.			Difference of dry and wet bulb. Therm.		Wind.	Mean amount of cloud.	Humidity. Saturation, 100.
	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
			Mean	Min.	Max.	Mean	Max.			
1862	In.	In.	•	•	•	•	•	NE. to SE.	10	810
1st.	29.82	.04	58	54	64	4	6	NE. to SE.	1	754
2d.	29.77	.06	70	56	82	5	8	NE. to SE.	8	800
3d.	29.90	.10	75	63	85	5	8	NE. to SE.	10	890
4th.	29.90	.10	54	48	60	2	3	N.E.	10	890
5th.	29.92	.10	60	50	70	5	9	N.E.	8	642
6th.	29.90	.08	60	50	72	9	12	NE. to SE.	3	510
7th.	29.70	.17	67	55	77	9	15	NE. to SE.	6	540

REMARKS.—1st. Light rain morning and evening. 2d. Sultry; variable sky during the day. 3d. Fog a.m.; variable day. 4th. N. E. rain storm, very heavy P.M.; five inches fell in twelve hours. 5th. Rain early A.M.; clear late P.M. 6th. Fresh wind; variable; clear evening. 7th. Variable; sultry A.M.; fresh P.M.; rain with thunder and lightning late at night. Six inches of rain fell on a level during the week.

SPECIAL NOTICES.

NEW YORK ACADEMY OF MEDICINE.—Dr. S. S. PURPLE will read the *Memoir of the late John Stearns, M.D.*, the first President of the Academy, on Wednesday evening, June 18th. After which, the subject of "Ergot" will be discussed.

DR. ELISHA HARRIS

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" " 5—6 P.M.

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[COPY.]

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Wm. H. Davol, M.D., late Physician

to L. I. College Hospital, Brooklyn, removed to St. Paul, Minn.

References.—C. L. Mitchell, M.D., T. L. Mason, M.D., Prof. E. N. Chapman, M.D., of Brooklyn; Prof. Austin Flint, M.D., Prof. B. F. Barker M.D., of New York.

THE FIRST NUMBER OF THE
American Journal of Ophthalmology

JULIUS HOMBERGER, M.D., EDITOR.

JUST PUBLISHED.

CONTENTS.

On Diphtheritis of the Conjunctiva. By Dr. Graefe.

On Strabismus Concomitans. By the Editor.

The Universal Society of Ophthalmology.

Journalistic Reports.

Paris Correspondence, etc., etc.

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Clinical Essays, by B. W. Richardson, M.D. Svo. London, 1862. \$2.00.

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Consumption, its Early and Remediable Stages. By Edwards Smith, M.D. Svo. London, 1862. \$3.25.

BAILLIÈRE BROTHERS, 440 Broadway, N. Y.

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Gmelin (L.) Hand-Book of Chemistry. Vol. I. 2d Edition, revised. Svo. London, 1861. \$3.25.

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Epilepsy: its Symptoms, Treatment, and Relation to other Chronic Convulsive Diseases, by J. R. Reynolds, M.D. London, \$1.25.

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Sent Free by Mail on Receipt of Price.

On Long, Short, and Weak Sight, and their Treatment by the Scientific Use of Spectacles. By J. S. Wells, M.D. Svo. London, 1862. \$1.57.

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Sent Free by Mail on Receipt of Price.

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